Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $180,066.36, for dates of service 07/18/01 and extending through 08/14/01.

   b. The request was received on 04/01/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 01/28/02
   b. UB-92
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 06/26/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 06/26/02. The response from the insurance carrier was received in the Division on 07/11/02. Based on 133.307 (i) the insurance carrier's response is untimely so the Commission shall issue a decision based on the request.

3. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

   "On behalf of (Provider), we have reviewed the claims and payment for the above hospital admission. Our findings reveal this claim, in the amount of $371,789.50, has not been paid according to the hospital fee guideline published by the Texas Workers Compensation Commission (TWCC).

   …The denial letter dated 12/14/01 stated 'No additional payment is being made as the payment already by (Carrier) has been determined to be fair and reasonable with the consideration of the stop loss fees and the documentation submitted.'

Upon telephone clarification on how this claim was processed, we were told they utilized data within their system to establish *an average hospitalization daily charge of $4545 per day* times the 27 days and that amount was considered fair and reasonable charges for audited charges times the 75% stoploss methodology."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 07/18/01 and extending through 08/14/01.

2. The Provider billed the Carrier $371,789.50 for the dates of service 07/18/01 and extending through 08/14/01.

3. The Carrier made a total reimbursement of $98,185.14 for the dates of service 07/18/01 and extending through 08/14/01.

4. The amount left in dispute is $180,066.36.

V. RATIONALE

Medical Review Division's rationale:

The medical reports indicate that the services were performed. The medical documentation submitted by the Requestor indicates that the total hospital bill was $371,789.50. Per Rule 134.401 (c)(6) (A)(i)(iii), once the bill has reached the minimum Stop-Loss threshold of $40,000.00, the entire admission will be paid using the Stop-Loss Reimbursement Factor (SLRF) of 75%. Per Rule 134.401 (c)(6)(A)(v), the charges that **may** (emphasis added) be deducted from the total bill are those for personal items (television, telephone), not related to the compensable injury, or if an onsite audit is performed, those charges not documented as rendered during the admission may be deducted.

The carrier is allowed to audit the hospital bill on a per line basis. Per the EOB, the Carrier deducted $5,968.60 for supply/implants. The Carrier denied "Hospital Services" as and the implantables with the denial code of "M-THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON THE BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011(B)." In reading Rule 134.401 (c)(6), additional reimbursement **only** (emphasis added) applies if the bill does not reach the stop-loss threshold. The hospital is required to bill, "…usual and customary charges…" per Rule 134.401 (b)(2)(A). The carrier should audit the entire bill to see if the charges represent "usual and customary" amounts. This would include the implantables. Therefore, the carrier would audit the **implantables** and reduce them to "usual and customary" charges if they thought the bill for implantables was inflated. (It would not be appropriate to start out the audit by automatically reducing the cost of the implantables to cost + 10%, which is indicated in the Medical Fee Guideline since the rule states this method is used only for the per diem reimbursement methodology.) There was no documentation submitted by the carrier to indicate that the reduction of the implantables

was based on anything more than reducing them up front to cost + 10%. There is no documentation to indicate that the carrier attempted to determine the usual and customary charges billed by other facilities for implantables in the same geographical region as the hospital. Even if the charge appears to be inflated based on an invoice or based on information from the fee guidelines, the carrier must determine what is usual and customary for those items in that region and billed by other facilities. If other facilities only bill cost + 10% for implantables, some evidence of that determination would be needed if the hospital challenges the reimbursement amount. The carrier would also subtract any personal items or items not related to the compensable injury and then determine the final amount to see if the bill would be paid at the per diem methodology or the stop-loss methodology.

The hospital has billed its "usual and customary charge" of $21,334.75 for the implantables. The carrier has not submitted evidence of what is usual and customary in that region for these items.

Therefore, the total reimbursement will be calculated in the following manner:

Total charges are $371,789.50-minus-Pt. convenience of $787.50=$371,100.20
Multiply the audited charges of $371,100.20 x 75%
$371,100.20 x .75= $278,251.50
The carrier paid $98,185.14
$278,251.50 - $98,185.14 = $180,066.36
Therefore, additional reimbursement is recommended in the amount of $180,066.36.

The above Findings and Decision are hereby issued this 10th day of September 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $180,066.36 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 10th day of September 2002.

Judy Bruce
Director of Medical Review
Medical Review Division

JB/mb

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.